HEALTH PROFESSIONS SCHOLARSHIP PROGRAM COST DATA WORKSHEET (Claim For Reimbursement)														
1. Name (Last, First , MI)						2. SSN 3				3.	. DATE FORM COMPLETE			
4. PERMANENT MAILING ADDRESS (Include Zip Code)				5. CURRENT MAILING ADDRESS (Include Zip Code)							6. YOUR TELEPHONE NO.			
7. NAME OF INSTITUTION				8. ADDRESS OF INSTITUTION							9. TELEPHONE NO OF INSTITUTION (Incl Area Code)			
9a. STUDENT E-MAIL ADDRESS									_	11.PROFESSIONAL TRAINING				
10. COURSE OF STUDY Medicine Osteopathy Dentistry								Other		BEGIN (Mo.Yr.) GRAD (Mo. Yr.)				
ITEM 12 HEALTH INS, HEPATITIS B VACCINE, USMLE I & II, ERAS FEE											COST			
INS Inclusive Dates FROM: YR-MO-DAY TO: YR-MO-DA								YR-MO-DAY	,					
					<u> </u>									
TOTAL														
ITEM 13	ITEM 13 TEXTBOOK/AUTHOR EQUIP MEDICAL SUPPLIES									DATE OF PURCHASE COST				
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TOTAL TAXES FOR ITEM 1	3									+-	OTAL	-		
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	GRAND TOTAL ITEMS 12 & 13													
In accordance with 10 U.S.C. 4302 your address and telephone number are solicited so you may be called to correct problems as they arise. Your SSN is solicited under Executive Order 3397, AR 37-104-3 and DODPM to identify your pay account to insure you would be receiving payment due. All information is voluntary														
14. All of the above items purchased by me and substantiated by attached receipts are required of all students in my field of study and year group at this institution. All information provided herein is true and correct to the best of my knowledge and belief.									STUI	<b>FUDENT</b>				
15. VERTIFICATION	OF REQUIREMEN	NTS (	WITI	H GRAN	D TC	TAL	AMO	UNT	BY SCI	100	OL OFFICIAL	\$	-	
DATE TYPED NAME AND POSITION OF SCHOOL OFFICIAL SIGNATION														